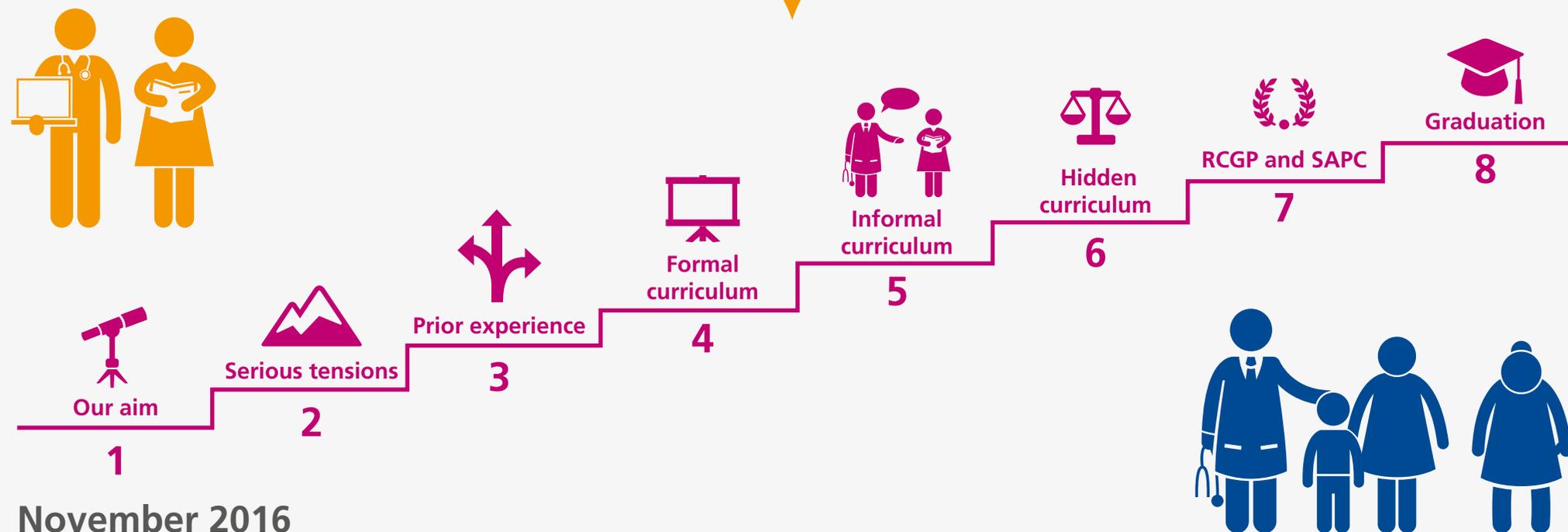


By choice – not by chance

Supporting medical students towards future careers in general practice



Preface

It has been a great privilege to Chair this collaborative task force under the joint sponsorship of Health Education England (HEE) and the Medical Schools Council (MSC). I gratefully acknowledge the support of all the organisations and their representatives, the input from the medical schools and the contribution of the younger doctors and medical students. All their views have been invaluable and fed by a true motivation to move general practice recruitment forward through an inclusive collaborative process.

The medical school environment is complex. The influences on students, as they explore career options in medical school, are multi factorial. They reflect hidden values and expectations firmly entrenched within the medical profession. Many are embedded in the traditional perception of primary as distinct from, and of lower status than, secondary care; a concept established at the inception of the NHS. Yet, despite these influences, recruitment to general practice in the past has been good. Currently morale in general practice is low and there are alternative openings available across many specialties, abroad and in other professions. This adds to the complexity.

The challenge, at this point in time, has been to seek practical feasible recommendations, which hold strong, positive commitment to deliver and contribute to solving

the current crisis. Our aim has not been to blame but to catalyse change. Fortunately the student voice, as is so often the case, has been honest, powerful and, above all, consistent across the diverse medical school environments. Students hold different perspectives and wider visions for the future of primary care than, perhaps, their educators. They can see a way forward which suits their career ideals. If we can harness this, and successfully collaborate within and across all professional bodies, the workforce needs of future health and care delivery can become a reality.

The report is co-sponsored by HEE independent of the devolved nations alongside MSC which holds UK wide responsibility. To achieve alignment, where recommendations are made to HEE, these should also be considered as recommendations to the relevant body within the devolved administrations: NHS Education Scotland (NES), Northern Ireland Medical and Dental Training Agency (NIMDTA) and the Welsh Government and Wales Deanery. The findings are generalisable across all medical schools.

The report aims to offer an honest and practical insight of the students' journeys into and through medical school and to illustrate how they weigh the pros and cons of a career in general practice. I hope you too gain from their experience. Students have no intention of becoming General Practitioners by chance and certainly cannot be easily swayed from their choice. We all hold a responsibility to ensure they are supported to make good decisions compatible with their personal aptitudes and informed by values and views consistent with the needs of future, and not past, health and care delivery.



**Professor Val Wass OBE
Chair**

Biographies

Professor Val Wass OBE

BSc (Hons), FRCGP, FRCP, MHPE, PhD, PFHEA, FAcadMed

Emeritus Professor of Medical Education, Faculty of Medicine and Health Sciences, Keele University



Val Wass retired, last year, after five years as Head of the School of Medicine at Keele University, to take up a consultancy role as Emeritus Professor of Medical Education in the Faculty of Medicine and Health Sciences at Keele.

Originally she worked in Paediatric and Adult Nephrology for ten years before developing a strong interest in holistic generalist patient care and moving to train in general practice. After eleven years as a General Practitioner in Kent she joined Academic Medicine at Guy's, Kings and St Thomas's Medical school as a senior lecturer (1995-2003), and then became Professor of Community Based Medical, University of Manchester (2003-2009) before moving to Keele (2009-2015).

She studied the International Masters in Health Profession Education (MHPE) at Maastricht University in the Netherlands. This led to a PhD in Maastricht on assessment methodology and increasing international consultancies; both undergraduate and postgraduate. She has worked extensively across the UK and in more than 25 countries. Awards include the RCGP William Pickles and President's International Medals and the ASME Gold Medal for an outstanding contribution to medical education. In the 2015 New Year's Honours she received an OBE.

Professor Simon Gregory

MMedEd, FAcadMed, FHEA, FRCGP, FRCPE

Regional Director and Dean of Education and Quality Health Education England



Simon is Regional Director and Dean of Education and Quality (DEQ), Health Education England (HEE), Midlands and East and national SRO for Primary Care having been DEQ & Postgraduate, Health Education East of England. He is also Honorary Professor at Norwich

Medical School, University of East Anglia (UEA) and Visiting Professor at Anglia Ruskin University (ARU) and the University of Pavia, Italy (teaching appointment), and a Fellow of Homerton College Cambridge. He was COPMeD Lead Dean for Selection and Recruitment, Obstetrics and Gynaecology, Sexual and Reproductive Health, Pre-Hospital Emergency Medicine and Nutrition and now leads for HEE on Primary and Community Care. Simon is Chair of the UK Medical Recruitment Programme Board and the GP Workforce 2020 Programme Board. He also sits on the Genomics Advisory Board, serves on the HEE Medical Workforce Advisory Group and is Chairman of the RCGP Committee on Medical Ethics and the University of Cambridge, East of England Military Education Committee.

Simon is clinically trained as a GP in Northampton previously being a GP Partner at King Edward Road Surgery, Northampton. He is now a Consultant to and Salaried GP at the practice. His research interests are selection methodology, "value-added" in medical education and quality of education, training and care and health outcomes and performance, and his clinical interests respiratory medicine and women's health.

Katie Petty-Saphon MBE

MA, PhD, FAcadMed

Chief Executive Medical Schools Council



Katie Petty-Saphon is the Chief Executive of the Medical Schools Council and of MSC Assessment. The secretariat she heads also runs the membership organisations for the Dental, Pharmacy and Vet

Schools Councils as well as the Association of UK University Hospitals. She worked in industry for many years, founding three successful companies. She was COO for Sir John Tooke's Independent Inquiry into Modernising Medical Careers a contribution which was marked in the 2011 New Year's Honours. She is a Trustee of the UK Clinical Aptitude Test Consortium and of the Schwab Westheimer Trust and a former Trustee of the Royal Medical Benevolent Fund. In 2015 she was elected a Fellow of the Academy of Medical Educators. She is immediate past President of the Newnham College Associates, a former Governor of the University of Hertfordshire and former Deputy Chair of Princess Alexandra Hospital NHS Trust. She marked the millennium by planting 10,000 trees which have now grown into a dense wood in Wendens Ambo, Essex.

Executive summary

Background: Recruitment into general practice has become a major issue. Changes in health and care delivery and organisation have put greater pressure on primary care. Workforce needs for General Practitioners are not being met. Although several interventions are under way to improve recruitment, to date little attention has been paid to the role of medical schools in promoting primary care as a career. There is increasing awareness that statistics for entry into core general practice reveal marked differences across schools. None reaches the estimates required for the future workforce. Health Education England (HEE) and Medical Schools Council (MSC) have jointly sponsored this work to investigate collaboratively what can be done in medical schools to produce a realistic General Practitioner output.

Methods: A task force with representation from the British Medical Association (BMA), HEE, junior doctors, MSC, Royal College of General Practitioners (RCGP) and Society for Academic Primary Care (SAPC) was established to investigate and make recommendations to HEE. A literature review formed the evidence base from which the group held three workshops on “student selection”, “the curriculum” and “career promotion”. Evidence was heard from invited experts. Meetings were held with staff and students at five medical schools, selected to reflect output characteristics. A strong and consistent student voice emerged highlighting their experience of general practice. This formed a sound platform both for the report’s narrative and for reaching achievable recommendations.

Findings: Medical schools are complex institutions extending far beyond the University campus into hospital, general practice and community organisations. Students are significantly influenced not only by the complex context in which they learn but also by Royal Colleges, research organisations and the media. They are not swayed by marketing but make carefully measured choices weighed against their medical school experience. We identified three very significant but deeply seated issues affecting students; “tribalism”, “negativism” and “finance”.

Students experience an uncomfortable divide between primary and secondary care across which they meet unfortunate professional tribalism leading them to perceive primary care of “lower status”. This must now be addressed as unacceptable. What may sometimes be said in jest does, we learnt, impact on student choice. Work to challenge professional denigration is essential. This must disseminate down from the Academy of Medical Colleges through all organisations.

Currently general practice morale is low and students meet strong negativism within the profession itself. Students on placements experienced the stresses General Practitioners were facing in their daily work and, in some instances, were actively discouraged by them from entering primary care. Students also perceive that general practice fails to offer the variety of academic challenge they aspire to. The academic status and visibility of primary care across Universities is diminishing rather than expanding. Any curriculum change or medical school action will not succeed unless this

professional negativism is improved, general practice is accepted as a specialty in its own right and the academic profile of general practice is strengthened.

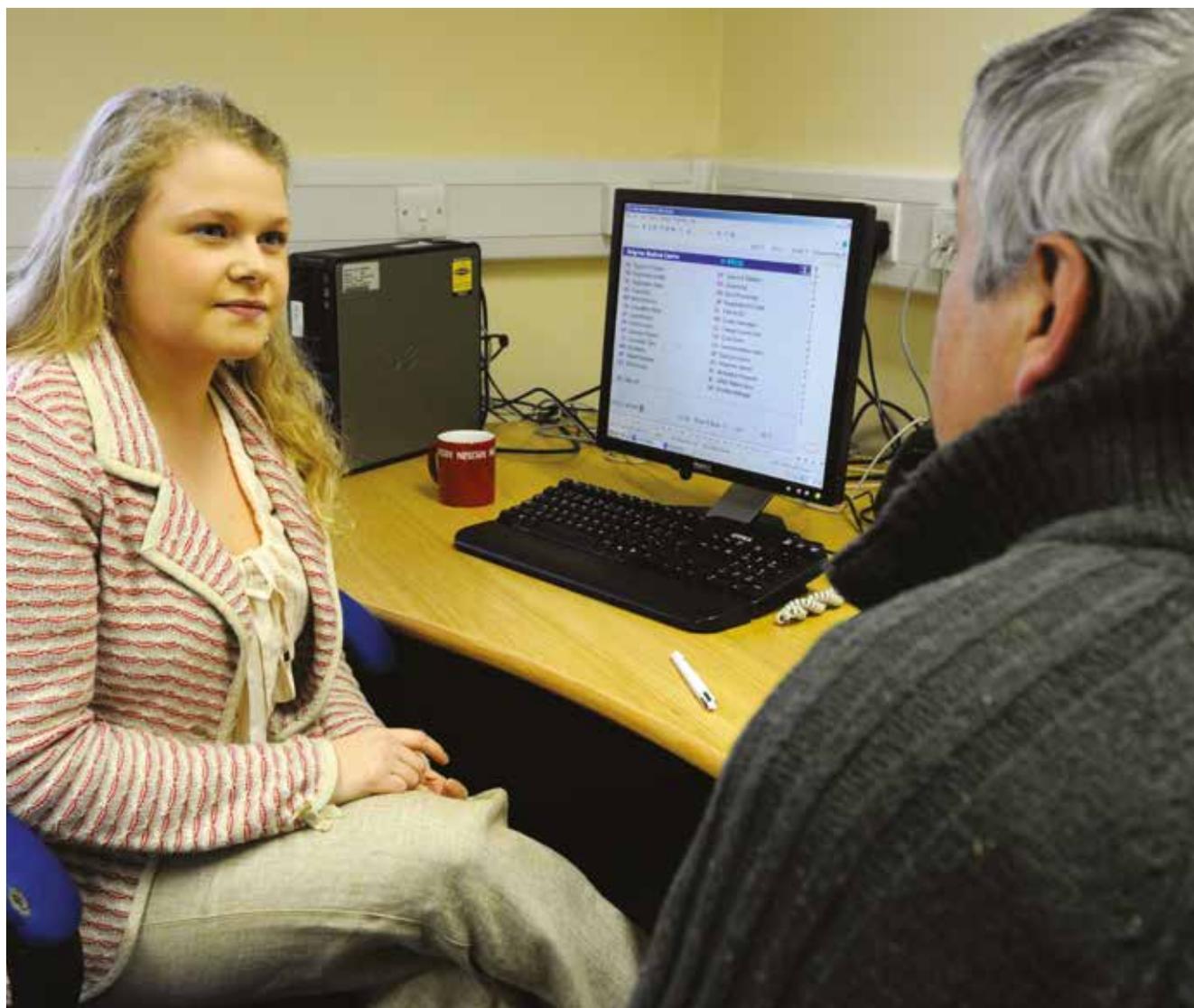
Above all, the tensions around financing undergraduate (UG) education need resolution. Addressing the lack of equity of reimbursement for UG education teaching across the different health care settings is absolutely fundamental. The Department of Health, with HEE, should rapidly progress the current review of funding models, to ensure that, as patients are cared for increasingly in the community, students can follow them and learn. The current model is not working. Appropriate funds must be available to release General Practitioners to teach without compromising patients. Adequate funding structures, with equitable transparent accountability, must be urgently achieved to educate students in different NHS contexts outside secondary care. Without this they exit with little understanding of current, let alone future, health care delivery.

Faced with these three negative forces we have sought to formulate achievable and feasible recommendations which can be immediately introduced within medical schools. The report follows the student journey through medical school identifying areas, at times suggested by students themselves, where change is feasible and where the responsibilities for achieving them lie. Students lack, yet want, an understanding of what being a General Practitioner involves. The distinction between “generalism” and “being a General Practitioner” is blurred. This failure to define and represent general practice as an academic specialty in its own right

within the curriculum can be addressed. We make recommendations for medical schools based on six stages of the student journey: *"Prior experience and selection"*; the *"formal"*, *"informal"*, and *"hidden curriculum"*; *"the external influence of the RCGP and SAPC"* and *"expectations on graduation"*. Given the complexity of the medical school experience collaborative leadership is, in many areas, absolutely essential to ensure messages are consistent and clear to students. Maximum use must be made jointly of resources.

These recommendations can come to fruition if all the organisations supporting this task force commit to work collaboratively to implement them. Each recommendation is attributed to a lead organisation and supporting stakeholders. It is beholden to all to work together to deliver them. HEE, with MSC, will hold a review one year post publication to report on organisational strategy, progress and outcomes measured against the recommendations.

Conclusion: Collaboration is absolutely essential to raise the profile and future vision of general practice. Medical students want a career in general practice to offer intellectual challenge, academic status and diversity. Their current experience of primary care at medical school fails to meet these expectations. The future of general practice is exciting and has the potential to offer the challenges and flexibility of experience many students want. It is the responsibility of all those delivering undergraduate education to ensure medical students are supported to recognise this. Failure to do so will result in a workforce unprepared for future patient needs.



Recommendations:

Section 2: serious tensions at the primary – secondary care interface

Recommendation 1:

Current funding systems, processes and guidance for distributing monies for undergraduate teaching must be reviewed urgently to enhance and ensure equity for the quality and quantity of learning for medical students across the health care system.

Lead Responsibility: DH

Supported by: BMA GPC HEE MSC NHS England RCGP SACP

Outcome measure: Current discussions to progress to ensure an appropriate tariff can be introduced by April 2018

Section 3: the student experience before medical school entry

Recommendation 2:

Develop, promote and disseminate positive, realistic awareness and understanding of general practice to pupils in primary and secondary education. Areas of focus must include:

1. Medical schools outreach and widening participation activities
2. Fora to provide interaction between school/college pupils and staff

Lead Responsibility: MSC

Supported by: BMA CCGs GPC HEE Other GP primary care organisations RCGP SACP

Outcome measure: MSC led Audit of resources

Recommendation 3:

Improve access to and quality of work experience in general practice for prospective medical students. Work to achieve this should be collaborative and include:

1. Sharing and co-promotion of existing materials, toolkits and models
2. Practices to be encouraged to provide structured work experience opportunities

Lead Responsibility: MSC

Supported by: All primary care commissioners including NHS England and CCGs BMA GPC HEE RCGP SACP Medical Schools

Recommendation 4:

All medical schools must ensure that General Practitioners contribute significantly in all selection processes. Schools must build on the work of MSCSA on selection methods including values based recruitment and the UK Medical Education Database (UKMED) to understand characteristics influencing career trajectory and the differential general practice workforce outputs.

Lead Responsibility: Medical Schools

Section 4: the influence of the formal curriculum

Recommendation 5:

All medical schools must revise their undergraduate curricula to ensure they develop to reflect the patient journey through different health care settings and offer a more integrated less specialty organised approach. The GMC must review its Outcomes for Graduates to provide guidance appropriate to rapidly changing workforce needs. This is essential to ensure students are prepared for more flexible careers and future health and care delivery.

Lead Responsibility: GMC

Supported by: Medical Schools

Outcome measure: Revised GMC recommendations in one year

Recommendation 6:

The formal curriculum must better inform medical students on NHS management and delivery at the primary – secondary care interface. Students should recognise the breadth and complexity of general practice care and be stimulated by the complex intellectual challenge. The business elements of, and career options within, general practice (e.g. partnership versus salaried or locum roles) need to be clear to students.

Lead Responsibility: Medical Schools

Supported by: GMC RCGP SACP

Recommendation 7:

General practice should be recognised as a specialty in its own right with a combined register.

Lead Responsibility: GMC

Supported by: BMA RCGP

Outcome measure: Single register with General Practitioners as Consultants in Primary Care

Section 5: the influence of the informal curriculum

Recommendation 8:

An increase in UG general practice placements must address improved quality, content, timing and variety. This should include exposure to (1) a variety of practices (large, small, rural, urban) (2) general practice Multi-Disciplinary Teams (3) the range of general practice services. Equitable and appropriate financial resourcing is essential to achieve this.

Lead Responsibility: Medical Schools

Supported by: GMC HEE RCGP SAPC

Recommendation 9:

Positive and enthusiastic General Practitioner role models should be identified and made visible across all medical schools. This includes enhancing and supporting the role of General Practitioner Specialist trainees (GPSTs) as educators and assessors and interaction in primary care between medical students and near peers in training.

Lead Responsibility: Medical Schools

Outcome measure: Directors of PG GP Education MSC PG Deans, RCGP Specialty Advisory Committee

Recommendation 10:

RCGP should evaluate fully the role of GP Societies, to optimise these societies and share good practice. General Practitioners need to be present at student career fairs. RCGP should work more closely with SAPC to link into medical schools.

Lead Responsibility: RCGP

Supported by: SAPC





Section 6: the influence of the hidden curriculum

Recommendation 11:

Work should take place to tackle undermining of general practice as a career across all medical school settings including primary care. This should include (1) incorporating “undermining” into Faculty development (2) teaching students about the hidden curriculum (3) developing student self-assertiveness to question denigration (4) improved feedback mechanisms to enable students to report safely on any serious undermining whilst on placement (5) work with the Academy of Medical Royal Colleges (AoMRC) to create a positive culture of professional respect.

Lead Responsibility: Medical Schools

Supported by: All Medical Royal Colleges AoMRC GMC
HEE MSC RCGP

Section 7: external influences: the RCGP and SAPC

Recommendation 12:

Academic training opportunities in primary care should become more accessible by (i) increasing the availability and reviewing the current structure and support for Academic Foundation Posts (AFPs), Academic Clinical Fellowship (ACF) GP posts and Academic Clinical Lectureships (ACLs) (ii) active promotion of these opportunities within medical schools (iii) recommendation to NHS England to meet its contractual obligation to provide contracts to Senior Academic General Practitioners (SAGPs) and ensure access to and funding of local and national Clinical Excellence Awards.

Lead responsibility: NHS England

Supported by: HEE NIHR SAPC UKFPO

Outcome measure: Contractual obligations achieved and increase in GP ACFs and AFPs

Recommendation 13:

All institutions influencing students should collaborate to raise the profile of academic general practice by ensuring (1) all students have access to, and are overtly valued and rewarded, for scholarly activity and visibly supervised by primary care leads (2) the profile of senior academic GP leaders is raised and appropriately acknowledged in all medical schools (3) Collaboration between the RCGP and SAPC is strengthened.

Lead responsibility: Medical Schools

Supported by: RCGP SAPC RCGP Clinical Innovation and Research Centre (CIRC)

Outcome measure: Report from RCGP/SAPC on agreed strategy

Section 8: student expectations on graduation

Recommendation 14:

Increasing the awareness of and supporting portfolio careers within general practice alongside the core role of a General Practitioner is crucial. Strong collaboration across all organisations is needed to ensure the range of opportunities within general practice is actively promoted within medical schools and students are offered a far better understanding of what being a General Practitioner can offer.

Lead Responsibility: Medical Schools

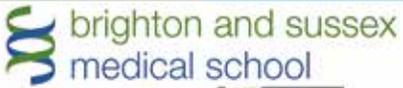
Supported by: by HEE RCGP SAPC

Recommendation 15:

Promotion of GP careers should be carefully considered to ensure that students have the ability and flexibility to make informed career decisions without feeling pressured by market forces: (1) Information provided should be honest, accurate and accessible (2) Existing General Practitioners should champion the vision of the profession as an exciting intellectually challenging and rewarding career.

Lead Responsibility: Health Careers

Supported by: HEE RCGP SAPC Medical Schools All General Practitioners



brighton and sussex
medical school



**General Practice isn't
just one career...**



Section 1

Our aim



“

Do not confine students with your own learning for they are born for another time”

Hebrew proverb

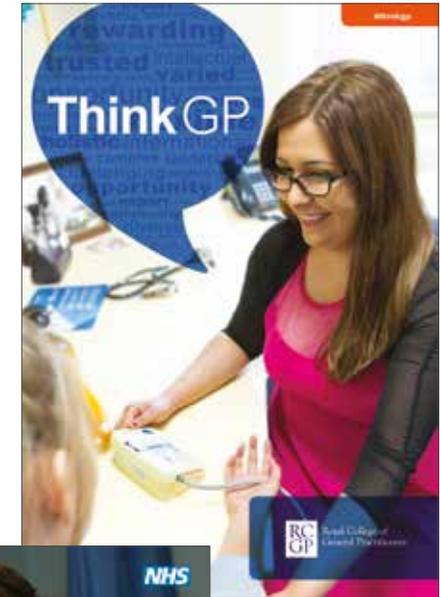
Section 1: Our aim

1:1 There are many current initiatives underway to improve the recruitment, retention and re-engagement of doctors with general practice. Entry from Foundation into general practice training remains well below target. There is a wide variation in entry into general practice training across medical schools (from 7%-30%) (Figure 1)¹ which suggests their influence is important and could be improved. Yet the impact of the medical school itself on a doctor's decision to enter general practice remains relatively unexplored.

1:2 This task force, supported jointly by HEE and MSC aimed to explore with key influential groups the factors within medical schools influencing general practice as a career choice. The BMA, General Practitioners in training, Medical School Deans, Postgraduate (PG) Deans, RCGP, SAPC and students were represented on the task group.

Figure 1: F2 Career Destination Report 2015¹

Proportion of medical school graduates of 2013 appointed to UK CT/ST in Autumn 2015





1:3 We were aware that it is an unfortunate, yet significant, time to be exploring these issues. Morale is low among doctors in the NHS, wide spread vacancies exist across many specialties, general practice is purportedly in “crisis” and junior doctors are in dispute over contracts. It can be argued that these alone are the significant causative factors.

The practices and cultures we found in medical schools have existed for a long time. Yet despite this recruitment to general practice in the past has been good. Weighing the significance of our findings against current trainee and GP low morale and willingness to change has been essential.

“

When I finish my F2 programme in 2 years’ time, do I want to join a GP training scheme that’s on its knees? It seems like it has been cut over the years in terms of real term cuts and it seems as though it’s a profession that’s struggling and in 5-10 years’ time it will still be struggling.

It’s very difficult to join what may be a sinking ship or at least a ship in a huge amount of difficulty. It is off putting. If you were joining some specialty where you get to do research, had funding, more jobs, such as Geriatrics where you know you will have a good career and things are going relatively well in that field, whereas GP seems more depressing.”

1:4 We identified a lack of clarity within undergraduate (UG) medical education between the concepts of “Generalism”² and “General Practice”³.

“Generalist knowledge is characterised by a perspective on the whole rather than the parts, on relationships and processes rather than components and facts; and on judicious, context-specific decisions on how and at what level (individual, family, system) to consider a problem”

Tricia Greenhalgh³

A holistic patient centred approach to problem solving underpins the GMC’s curriculum guidance in “Outcomes for Graduates”⁴ against which all medical schools are quality assured. Generalist skills are fundamental to UG training and must be learnt across many NHS contexts not only primary care. The key question when defining the curriculum is what learning outcomes relate to the role of the “General Practitioner” as distinct from the “generalist”? Generalist practice is a distinct expertise in clinical reasoning and decision making applicable arguably to all specialties. General Practitioners use these skills to deliver whole person medical care supported by an organisational context in the community⁵. The two are not synonymous and the concepts can be confused. If this is not clear to us as educators then it is not surprising that it is equally unclear to a medical student.⁶ (see section 4)

1:5 This has been a great opportunity to work to explore the student experience and what influences it. Medical schools are not defined university campus environments. Students experience, even from the first week of entry, a wide range of health care contexts (hospital trusts, primary care, social care etc.) and are influenced by Royal Colleges, research bodies and the media. The formal, informal and hidden curricula (see glossary) all hold the potential to affect a student in different ways. The influences are likely to be multifactorial.

1:6 Finally we acknowledge that the perspective of medical students and junior doctors may well differ from that of their educators. They are “born for another time”. The student voice emerged strongly throughout our work. We learnt they make intelligent weighed career choices from which they cannot be easily swayed. Although medical schools may influence their ultimate decision the process has to be understood from the Generation Y and Z perspective. This report offers the valuable insight gained from the students and trainees of their journey through medical school.

“GP/ family medicine is an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity, and a clinical specialty orientated to primary care”.

European definition of GP2011⁴

Section 2

Serious tensions



“

The truth is rarely pure
and never simple”

Oscar Wilde - The Importance
of Being Earnest 1895

Section 2: serious tensions at the primary – secondary care interface

2:1 "I think we should consider GP as a career but not be forced into it. It's not just a medical school problem"*

The students experience of general practice as a potential career is complex and certainly not "pure" or "simple". We learnt it is profoundly multifactorial and predominately beyond the direct influence of the formal medical school curriculum. Many factors impact on students as they navigate through training. There can be no linear quick fix such as a generic curriculum designed to produce more General Practitioners. Three uncomfortable, yet fundamental, negative forces driving against recruitment emerged; "Tribalism", "Negativism" and "Finance". These should not be ignored. Weighing what can and cannot be addressed to make feasible, achievable recommendations has been challenging.

2:2 "There is an anti GP rhetoric in medical schools"*

We consistently identified an uncomfortable and profound professional "tribalism". We found a serious "fault line" dividing primary and secondary care⁷. It pervades a student's impression of a career in general practice from pre-entry to medical school through to selection into general practice training. A most powerful, unacceptable, deeply ingrained professional disparagement, often in jest, exists between specialties. Students are led to perceive Primary Care to be of lower status to Secondary Care. The profession must acknowledge that this very entrenched practice can impact negatively on students weighing career options. Ingrained yet erroneous belief must be challenged.

"The disparity of esteem between the two branches of the medical profession was encapsulated by Lord Moran, Winston Churchill's physician, who described the career path to being a consultant as a ladder off which many fell, only to become General Practitioners."⁶

2:3 "GPs bash their own specialty" *

Simultaneously students meet a negativism towards general practice on placements. They reported being encouraged to pursue other careers by some General Practitioners disillusioned with their work. Ironically the driving force students experience on primary care attachments has a tendency to push them towards secondary care.

"We only get exposure to really busy practices where everyone is really stressed out/overworked. Every GP I've met has told me not to do general practice".

Medical Student

*All quotes marked with an asterisk are from medical students who attended the focus groups

The negativism promulgated within the general practice workforce, is reinforced by general practice professional organisations, and by national and social media, as the crisis in general practice is highlighted and more resources sought. This has had the unintended consequence of persuading students that it is not the career for them. General practice now has a great, most important opportunity to raise its profile and status.

2:4 Above all finance for undergraduate education remains fundamental to solving many of the issues outlined in the report. Slow progress in agreeing a primary care tariff to support teaching outside the secondary care tariff reinforces wide spread perceptions of its lower status and needs immediate attention. It devalues the resources needed for quality primary care placements⁷. Adequate resourcing is absolutely essential if General Practitioners are to have protected time to teach without detriment to patient care. There is a significant variation in the payments made for teaching and undergraduate placements in primary care and on average the allocation is two thirds of that made to hospital trusts. The bottom line is placements for general practice in medical school can only be successful if teaching in the community is adequately and appropriately resourced, with transparent accountability against that available for Hospital Trusts.

2:5 "GPs get paid to teach us – clearly some are doing it for the money and not the teaching." *

We found a fundamental misunderstanding arising from the current financial allocation and the tradition of the former Service Increment For Teaching (SIFT) (now known as the Undergraduate Medical Tariff (UGMT) which lies buried and invisible in hospital trusts. This reinforces tensions between secondary and primary care. Students perceive secondary care teachers volunteer and are not paid to teach them whereas General Practitioners need to be paid. Deans and undergraduate leads are frustrated that resources must be found to pay General Practitioners to attend additional selection and assessment processes. They fail to understand that reimbursement to cover patient care to release General Practitioners to teach is crucial.

2:6 Medical school GP leads consistently reported that lack of resources impeded them from extending time for students in primary care and indeed, at times, forced them to cut back. Traditional reimbursement systems do not mirror the current patient journey through the National Health Service (NHS) and the significant move of health care into the community. More transparent and equitable reimbursement for teaching is needed to permit flexible distribution of funds across different teaching contexts reflecting the increasingly integrated model of health professional training. A pilot model in South London offers an example.

Good Practice

2:6 Expanding undergraduate community placements: South London's potential solution

A pilot collaborative Darzi project between HEE, Community Education Provider Networks (CEPNs) and local Higher Education Institutions (HEIs) (St George's University of London, King's College London and University of Greenwich) aims to create a "pipeline" of students from different professions, including medicine, nursing, pharmacists and paramedics, into GP practices, whilst making networks of practices responsible for 'bundles' of undergraduate learners. For practices the advantages include a guaranteed income stream for education activities. For learners it increases opportunities for inter-professional and near peer learning offering a greater scope of experience in general practice.

For further information please contact

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2:7 Adequate resources must follow students across all NHS learning environments with equitable reimbursement across all sectors. A remodelling of the current distribution system may well prove necessary. The process of distribution of monies, by both HEE and medical schools needs to be transparent to assure all stakeholders that it is spent on education and not service delivery.

Recommendation 1:

Current funding systems, processes and guidance for distributing monies for undergraduate teaching must be reviewed urgently to enhance and ensure equity for the quality and quantity of learning for medical students across the health care system.

Lead Responsibility: DH

Supported by: BMA GPC HEE MSC NHS England RCGP SAPC

Outcome measure: Current discussions to progress to ensure an appropriate tariff can be introduced by April 2018

“Tell consultants to stop putting GPs down. It makes students feel as though it is a less valued career”

Medical Student

“Not enough GP practices take on medical students. It should be made compulsory - with an incentive”

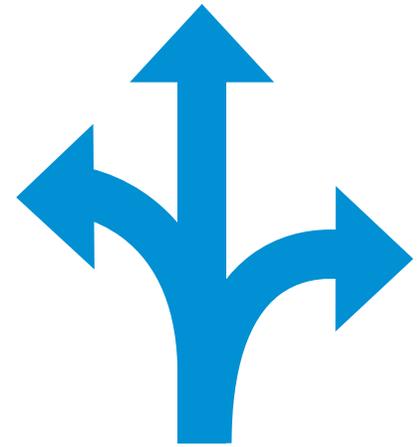
Medical Student



Section 3



Prior experience



“

I'd never really go to my GP other than for mundane things”

Firth et al¹⁰

Section 3: the student experience before medical school entry

3:1 "You have to imagine the sort of work they do" *

Many students enter medical school with very little concept of what being a General Practitioner involves. Their only experience may be based on attending the General Practitioner themselves for relatively minor illnesses. This reinforces the myth that General Practitioners deal only with "coughs and colds". Graduate students in contrast held more life experience and some had already identified a career in general practice as their ultimate goal.

“We are entering the game later and if people are graduating in their 30’s are they going to want to join a long training programme?”

Graduate entry medical student

3:2 "In terms of the media, General Practitioners are not coming across very well and this would put me off GP"*

Secondary care based TV series engage and attract students to hospital careers. Students commented on the relative dearth of general practice focused programmes but that they could influence them. They were well aware of the negative image the press and social media conjure of NHS primary care. Medical school websites too offer secondary care focused imagery which may encourage unrealistic perceptions of the future workforce. MSC is aiming to address this.

“General Practitioners Behind Closed Doors’ on TV – there is one GP who is rude, but generally it is great.

It enforces the perception that General Practitioners genuinely care and want to do their best for patients”

Medical Student

Good Practice

3:2 The Dean’s blog : Professor Paul Stewart Leeds Medical School

Although there will be resistance to change (dare I say particularly from general practices themselves) our remit is to meet the needs of our patients within the NHS – and change will happen. With it brings opportunity and many of us can see significant advances in training across the primary-secondary care divide that will make recruitment to a future career in “generalism” more appealing. Armed with innovation in medical technologies such as remote sensing and reporting devices, informatics and electronic patient records, new ways of working across community and hospitals and a commitment that future funding will be driven by patient outcomes rather than commissioning, the generalist approach to the care of your patients will be an exciting and attractive career choice.

What do I do when I qualify? General Practice, Generalism and Specialism - December 2015

http://medhealth.leeds.ac.uk/info/295/about_us/1251/the_deans_blog/2

3:3 This reports is set against three important documents all presenting forward thinking views highlighting the complexity of general practice and the need for change. The Future of Primary Care Roland Commission¹¹, GP Forward View¹² and The House of Commons Health Committee on Primary Care⁹, all aim to promote positively the future of general practice. Throughout we faced the reality that these publications were remote from the medical school experience and remained relatively unknown to students. They had no apparent influence.

Recommendation 2:

Develop, promote and disseminate positive, realistic awareness and understanding of general practice to pupils in primary and secondary education. Areas of focus must include:

1. Medical schools outreach and widening participation activities
2. Fora to provide interaction between school/college pupils and staff

Lead Responsibility: MSC

Supported by: BMA CCGs GPC HEE Other GP primary care organisations RCGP SAPC

Outcome measure: MSC led Audit of resources

Sir Bruce Keogh

In my view, it is a really hard job. They have to be clinically, intellectually and emotionally strong. I can say this as a cardiac surgeon where all our patients come to us kind of worked up... But day in, day out, General Practitioners are having to sort out the wheat from the chaff to identify major clinical problems masquerading as minor ailments... It requires a lot of intellectual flexibility and people have to be really tolerant individuals. It is one of the hardest jobs in medicine.

House of Commons Health Committee: Primary Care HC 408 p78

3:4 **"I was more open to GP prior to medical school, I did work experience there and really enjoyed it." ***

Preliminary work with primary and secondary school pupils and teachers suggests that much more could be done to promote general practice as a career. Both MSC and RCGP initiatives are underway to address this. Research has highlighted the very limited pool (approximately a fifth) of secondary schools from which medical schools receive applicants¹³. More publicity and widening participation may offer fertile ground for attracting students with the aptitudes for primary care.

Over a three year period around 80% of all medical school applicants came from just 20% of all secondary schools and 50% sent no applicants.¹²

Good Practice

3:3 Who's in Health?

This is a project run by the National Association of Head Teachers (NAHT), the Education and Employers Taskforce and MSC. It aims to enthuse and inspire young children to work in the NHS by introducing healthcare workers and students into UK primary schools. Best practice in outreach suggests that children should experience these aspirational concepts at a young age. They need to understand that what they learn at school remains useful to them once they start work. A number of General Practitioners have been involved in the project. Recruiting more is strongly recommended.

<http://www.naht.org.uk/welcome/news-and-media/key-topics/curriculum/naht-launches-medics-month-a-new-partnership-with-the-medical-schools-council/>



3:5 "The hospitals were more open to work experience – had to try about "50" GP practices"*

There were consistent reports of lack of opportunities for work experience in primary compared to secondary care. The limited availability has been partly compounded by General Practitioners themselves reluctant to take local pupils because of unfounded concerns about patient confidentiality. Work is in progress to dispel these myths and encourage General Practitioners to open their doors to those seeking to understand careers within medicine. Stronger collaboration between the MSC, RCGP, BMA and Primary Care Organisations is needed to maximise impact and resources.

Recommendation 3:

Improve access to and quality of work experience in general practice for prospective medical students. Work to achieve this should be collaborative and include:

1. Sharing and co-promotion of existing materials, toolkits and models
2. Practices to be encouraged to provide structured work experience opportunities

Lead Responsibility: MSC

Supported by: All primary care commissioners including NHS England and CCGs BMA GPC HEE RCGP SACP Medical Schools

Good Practice

3:5 General practice work experience toolkit

The MSC's work on selection and widening participation found it was more difficult for potential medical school applicants to get work experience in GP practices compared to hospitals. MSC worked with HEE to produce a toolkit¹³ designed to support General Practitioners in providing work experience placements and offering advice on how to maximise the benefit of these opportunities. The toolkit provides advice on issues such as confidentiality, indemnity and insurance which are often perceived as barriers to General Practitioners offering work experience.

<http://www.hee.nhs.uk/sites/default/files/documents/Toolkit%20for%20GPs.pdf>

Good Practice

3:4 Yorkshire GP Work Experience Project

In 2015 a GP work experience project ran across Leeds, Hull York and Sheffield University Medical Schools. The project placed 60 widening participation students on a three-day GP placement where they observed GP consultations (98%), spent time with the practice nurse (74%) and practice manager (72%), and accompanied the GP on home visits (70%). Workshops before the placement explored the role of a GP, professional conduct, reflection, confidentiality and ethics. Post-placement sessions offered sharing and reflecting on their experiences. Evaluation indicated this had value in promoting more positive views on GP as a career.

For further information on this project please contact
Dr Gail Nicholls
G.C.Nicholls@leeds.ac.uk

3:6 The Medical Schools Council Selection Alliance (MSCSA) has identified the range of methodologies used across medical schools to select students. Evidence based practice is strongly encouraged with an increasing focus on values based recruitment.

The diversity of approach may impact on the ultimate variation in workforce output (see 1:1) but is poorly understood. The establishment of the UK Medical Education Database (UKMED) may enable links between entry criteria and future career pathways to be explored. It is important that applicants see General Practitioners as role models actively involved in selection. Resources should be found by schools to ensure that General Practitioners are present on all selection panels and active in choosing our future workforce.

Recommendation 4:

All medical schools must ensure that General Practitioners contribute significantly in all selection processes. Schools must build on the work of MSCSA on selection methods including values based recruitment and the UK Medical Education Database (UKMED) to understand characteristics influencing career trajectory and the differential general practice workforce outputs.

Lead Responsibility: Medical Schools

Good Practice

3:5 Patient and public involvement in developing MMI stations

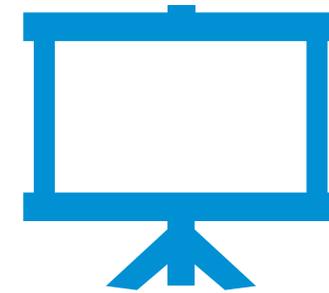
To select a diverse body of students, Leeds University Medical School uses a combination of academic scoring, a BioMedical Admissions test (BMAT) score, personal statement assessment and a multiple mini interview (MMI) (see glossary). A highly skilled team of clinicians from a wide range of specialties including General Practitioners, academics, senior students and the Patient Carer Community (PCC) plan, design and deliver the MMI stations. The PCC consists of circa 200 patients and carers from the local area. They use their stories and experiences to base the station scenarios in the real world. Public involvement has become the heart of the selection process. PCC has progressed to designing, delivering and solo marking stations across multiple healthcare specialties.

http://medhealth.leeds.ac.uk/medhealth-admin/info/831/core_activities
or for further information contact

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G.C.Nicholls@leeds.ac.uk

Section 4

Formal curriculum



“

You cannot teach a man anything;
you can only help him to discover it
in himself”

Galileo Galilei

Section 4: the influence of the formal curriculum

4:1 "Tell the rest of the world general practice is important and crucial"*

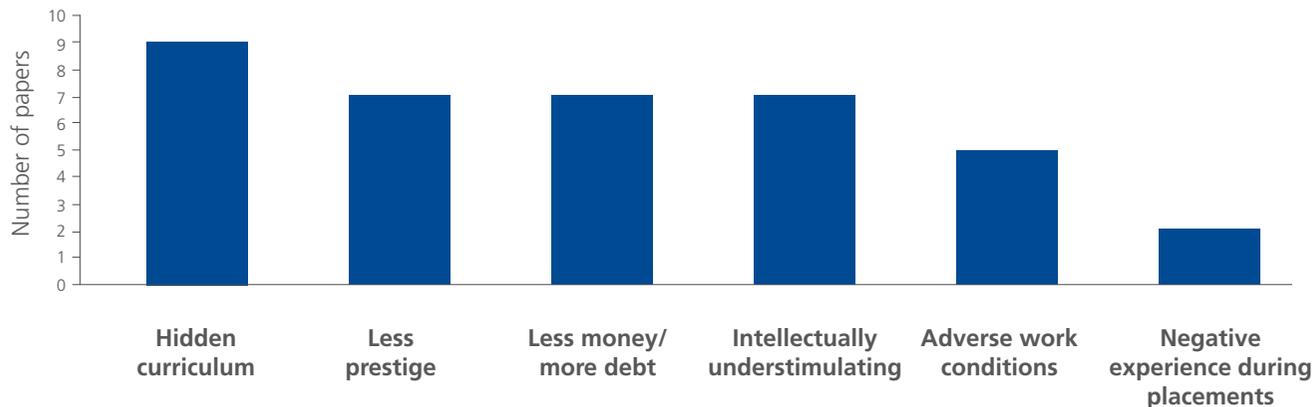
The diversity in medical school workforce output (see 1:1) suggests that the newer medical schools tend to produce proportionately more General Practitioners¹. The explanation is multifactorial. Schools differ in philosophy, demography, selection criteria etc. We visited five schools, both traditional and new, with contrasting workforce outputs.

4:2 "Feels as though we are being pushed into a general practice mind-set"*

We learnt that students are aware of the different ethos and culture reflected in the formal curriculum. They are far more influenced though by the informal and hidden curriculum than the formal teaching programme and the literature review supports this.

Figure 2: Literature Review

Why don't students choose GP? (Refer to Appendix 1 p50)



They emphasise the curriculum should not be used to market recruitment and "ram the message down their throats." This risks a negative impact. They will experience and make their own measured choices.

4:3 "A lot of the 'woolly' areas of the curriculum get stuck in general practice"*

The balance of the curriculum is however important. Health care is changing fundamentally and rapidly. Hospital stays are very much shorter with increasing specialisation as NHS services move into primary care. Ironically much of the contextualisation of basic knowledge and experiential learning from patients no longer lies in hospital but in the community where students spend little time. There is a need to integrate generalist learning appropriately and contextually across the spectrum of NHS delivery to enable students to understand modern health care.

"90% of all patient contacts happen in the community. This equates to 370 million patient contacts a year"

4:4 An international move to different delivery models for medical education is beginning to occur to mirror these changes. Learning is becoming more integrated with a move away from fixed rotation through specialties to more longitudinal attachments where students follow patients through the different areas of health care. New approaches are necessary to prepare students for the environment in which they will work.⁹

Recommendation 5:

All medical schools must revise their undergraduate curricula to ensure they develop to reflect the patient journey through different health care settings and offer a more integrated less specialty organised approach. The GMC must review its Outcomes for Graduates to provide guidance appropriate to rapidly changing workforce needs. This is essential to ensure students are prepared for more flexible careers and future health and care delivery.

Lead Responsibility: GMC

Supported by: Medical Schools

Outcome measure: Revised GMC recommendations in one year

Medical schools should recognise that they have a responsibility to patients to educate and prepare half of all the graduates for careers in general practice. Much greater emphasis should be placed on the teaching and promotion of general practice as a career which is as professionally and intellectually rewarding as any other specialism. Those medical schools that do not adequately teach primary care as a subject or fall behind in the number of graduates choosing GP training should be held to account by the General Medical Council.⁹

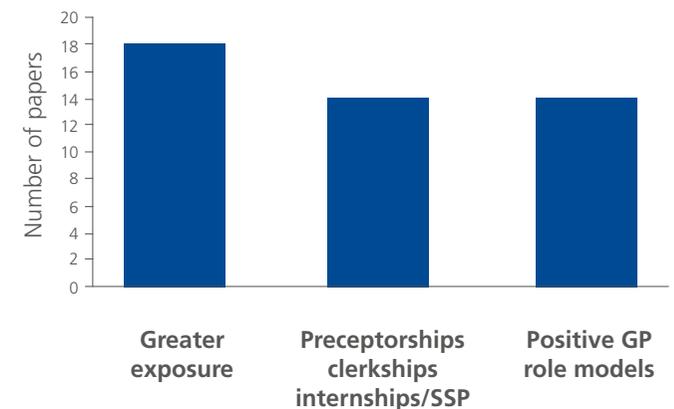
House of Commons Health Committee: Primary Care HC 408 (Paragraph 144)

4:5 “We do not have any real lectures from General Practitioners”*

For students the professional divide between secondary and primary care is less distinct. They suggest General Practitioners should be more visible in the medical schools delivering lectures and taking lead roles. General Practitioners hold much of the knowledge of patient care not seen in hospital particularly around basic paediatrics, non – communicable diseases, co-morbidity and ageing. The tendency for General Practitioners to focus on teaching communication skills and “softer” areas of the curriculum rather than knowledge delivery has not helped. Students suggest they should take a more visible “specialist” role in schools.

4:6 From the international literature, length of exposure to general practice, tends to influence subsequent career choice positively.

Figure 3: Literature Review
The medical school experience



Preliminary work correlating UK F2 entry into general practice training with time spent in the community at medical school suggests this may be the case (Alberti, personal communication). Our findings strongly point to quality of experience as the major influence (see section 7). We conclude both quantity and quality of exposure are relevant. Research is urgently needed to explore these associations in more depth.

4:7 "There is a need to demystify what a GP actually is"*

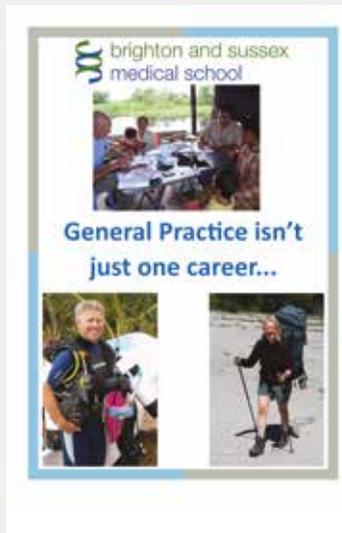
The formal curriculum must enable students to distinguish between "generalism" skills (see 1:4) learnt across all health care environments and "general practice" as a "specialty" career. Students told us they have difficulty understanding what being a General Practitioner involves. There has been a tendency to leave issues such as practice organisation and management to the postgraduate training curriculum. Yet students can be deterred by "hearsay" of needing mortgages to buy into practices, expensive examinations and believing it is not an academic specialty (see section 7). They need more clarity.

Formal teaching on the core knowledge and skills which distinguish general practice as a specialty distinct from those of broader generalist practice is needed.

Good Practice

BSMS student leaflet

Students may not fully understand the range of career options available in general practice. Brighton and Sussex Medical School has produced a career resource booklet in which medical students interview local General Practitioners working in various ways – e.g. General Practitioners with a special interest, in Clinical Commissioning Groups (CCGs), portfolio General Practitioners with research and education responsibilities.



https://www.bsms.ac.uk/_pdf/undergraduate/promoting-gp-as-a-career.pdf

4:8 "There's an element of pride regarding a specialty – people want to be seen as achieving or winning. GP isn't seen as a specialty."*

There is a strong case for declaring General Practitioners as specialists e.g. Consultants in General Practice or Primary Care. It no longer seems appropriate to separate rather than include them on the GMC specialist register.

We would support the current move by the BMA, supported by the RCGP, to address this and seek a change in legislation to form a single specialist register which includes General Practitioners. This would help address the perception that a separate register indicates that general practice is different and of lower status.

Recommendation 6:

The formal curriculum must better inform medical students on NHS management and delivery at the primary – secondary care interface. Students should recognise the breadth and complexity of general practice care and be stimulated by the complex intellectual challenge. The business elements of, and career options within, general practice (e.g. partnership versus salaried or locum roles) need to be clear to students.

Lead Responsibility: Medical Schools
Supported by: GMC RCGP SACP

Recommendation 7:

General practice should be recognised as a specialty in its own right with a combined register.

Lead Responsibility: GMC
Supported by: BMA RCGP
Outcome measure: Single register with General Practitioners as Consultants in Primary Care

Section 5

Informal curriculum



“

It is quality rather than quantity that matters.”

Seneca

Section 5: the influence of the informal curriculum

5:1 "In hospital you can hide from a team member you don't see eye to eye with"*

The reality of general practice placements, as experienced by students, does not necessarily mirror the formal curriculum's intentions. As outlined (4:6) tensions exist between quantity and quality. Students at all five schools gave a consistent message. For career choice, the quality of teaching really mattered. Many students experience excellent placements and value the one to one supervision very highly. However all weighed good against poor attachments either because the teaching was boring, General Practitioners were not motivated to teach or disillusioned with their work. Whereas students avoid poor experiences in hospital by seeking alternative teachers, in general practice they cannot. Good General Practitioner role models were powerful. Negative experiences were difficult to reverse.

“ I had a positive, enjoyable time with good learning experience there which helps. I've done other rotations where I've had a negative experience and that really puts you off. If you get put with a bad team, they don't respect you, they don't treat you very well and you just think 'What is the point?'"

Medical Student

5:2 "If we all had an enthusiastic GP it would be great: only 50% seem 'up for it'"*

Students valued seeing a variety of practices. They felt they were on their own voyage of discovery given the lack of learning on NHS models of primary care delivery within the formal curriculum. Some practices involved students in practice meetings, case conferences, visits to CCGs. This was appreciated. Some students expressed views that revealed deep negative misunderstandings of primary care e.g. lack of multidisciplinary teams and profound isolation. Placements were influential but "hit and miss". The more practices you experienced, the more favourable the outcome in terms of career choice.

“ A pretty positive experience really, the General Practitioners were really good, they had a good team. They were critical of GP in a way but weren't overly critical, they seemed to have a good view of it. I think it would have been nice to go to more than one GP practice.

Perhaps spending 4 weeks in one practice and 4 in another might have been good as they would have been different beasts.”

Medical Student

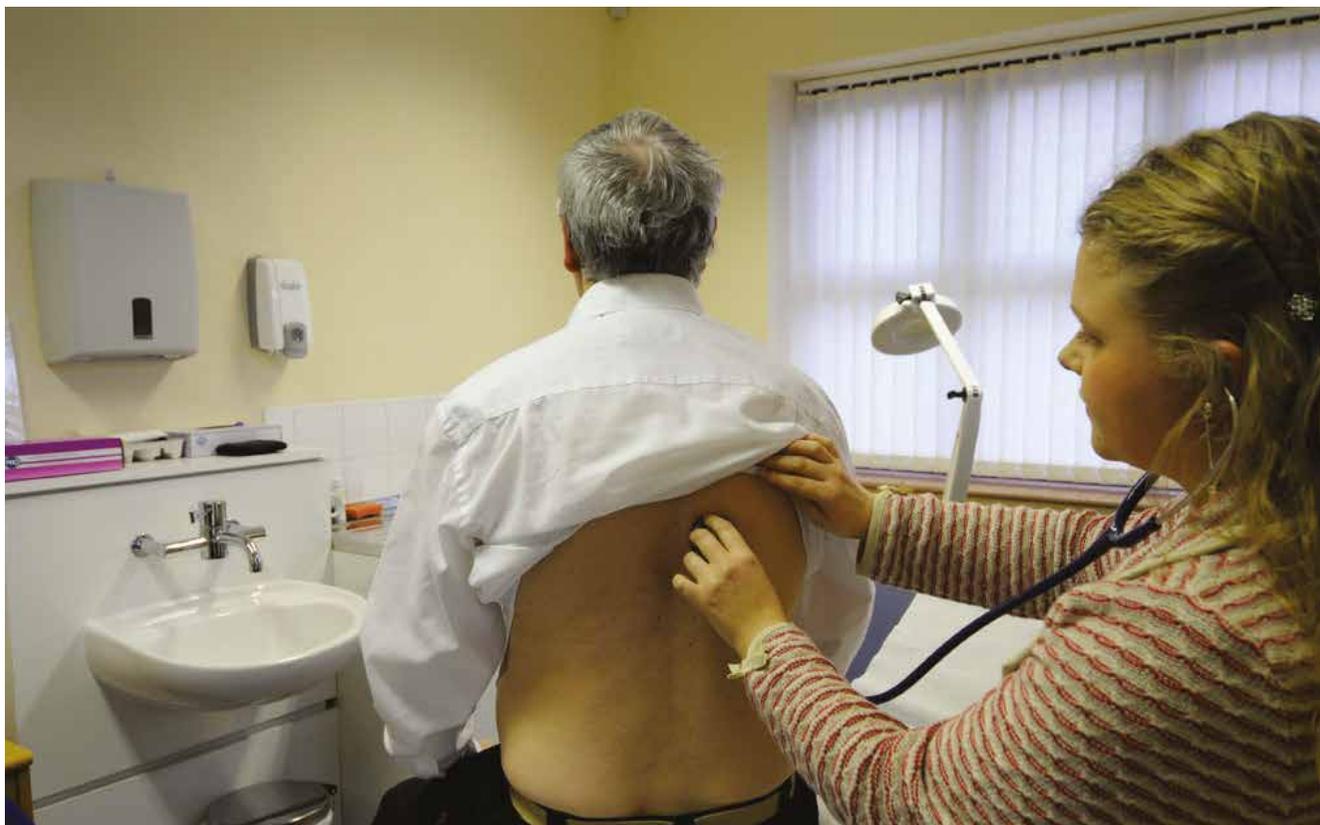
5:3 "There's a lot of responsibility on a GP placement. You are one person with one patient. It's kind of empowering in a way"*

We conclude it would be unwise to push for longer exposure to primary care and ignore the current need to improve quality. We learnt from all site visits and medical school deans that current delivery is impeded by General Practitioner withdrawal from teaching because of pressure on patient services and financial constraints due to a lack of agreed primary care tariff. The uncomfortable truth is that general practice placements must be equitably resourced to enable students to appraise fully the career opportunities they offer them. Poor quality teaching puts them off. The GMC in Good Medical Practice emphasises the role of a doctor as a teacher. (see <http://www.gmc-uk.org/guidance/>). The RCGP, GPC and BMA should collaborate with the MSC in emphasising to their General Practitioner membership the importance of engaging with UG education.

Recommendation 8:

An increase in UG general practice placements must address improved quality, content, timing and variety. This should include exposure to (1) a variety of practices (large, small, rural, urban) (2) general practice Multi-Disciplinary Teams (3) the range of general practice services. Equitable and appropriate financial resourcing is essential to achieve this.

Lead Responsibility: Medical Schools
Supported by: GMC HEE RCGP SAPC



Good medical practice point 39. "You should be prepared to contribute to teaching and training doctors and students."

5:4 "This person could be you in a few years' time"*

We consistently heard of excellent general practice role models in practices and within the medical school. Students repeatedly suggested General Practitioners should be more visible delivering lectures, taking lead roles, promoting primary care research and as personal tutors. Enthusiastic motivated General Practitioners impact powerfully on career choice and should be encouraged at every level of curriculum delivery. Students are also attracted to the potential of general practice academic careers where clinical responsibilities are shared with research or education. This helps negate poor demotivating experiences on placements. General Practitioners as academics are not sufficiently visible. (see section 7).

“ It would be nice to have a clinical supervisor who is a GP. It would be a good first step”

Medical Student



5:5 “Most of the time in hospital we pick up from F1s whereas in practice we tend to be with a senior GP”*

Students pointed to the absence of exposure to general practice specialty trainees (GPSTs) as teachers. They generally met more senior tutors. Yet trainees in hospital medicine were very influential in explaining the career trajectory they had chosen. The lack of contact with their near peers contributed to the mystique and misunderstandings (see 4:8) surrounding the realities of general practice training. Yet it is a doctor’s responsibility to teach. Involving General Practitioners more actively in teaching UGs offers a positive way forward.

Good Practice

GPST Ambassadors to promote general practice to Dorset schools

The Dorset GP Centre has selected “GP Ambassadors” from their cohort of GPSTs and contacted all 33 secondary schools in the region to offer careers advice. Ambassadors visit schools with a presentation and provide hands-on experience to strengthen applications and cement aspirations for a medical career. Subsequently local training practices provide GP Work Experience Placements and, with the three acute hospital trusts, Introduction to Medicine Courses, to encompass both acute and community settings. This scheme demonstrates that a GP centre is well placed to co-ordinate inclusive and comprehensive medical careers advice and opportunities to all potential medical students across the region.

Good Practice

Locally funded academic posts for general practice:

HEE West Midlands and North East have worked with local Universities (and other stakeholders) to allow extension of GP training by 3-12 months. These placements provide enhanced educational experience and academic qualifications in education, research, leadership and global health. The trainee is employed full time in a GP training practice and released to the University for the academic training. These posts are popular. They recruit and retain talented trainees to the region where they interact as near peer GP role models with medical students.

Recommendation 9:

Positive and enthusiastic General Practitioner role models should be identified and made visible across all medical schools. This includes enhancing and supporting the role of General Practitioner Specialist trainees (GPSTs) as educators and assessors and interaction in primary care between medical students and near peers in training.

Lead Responsibility: Medical Schools

Outcome measure: Directors of PG GP Education MSC
PG Deans, RCGP Specialty Advisory Committee

5:6 "There is a really good Paediatric Society but not for GP. It would be really good if there was more done around it" *

The RCGP is carrying out important work promoting student GP Societies in all schools to raise the profile of general practice.

When asked about the influence of the RCGP on their career choice this was the main link students held with the college. We heard some mixed views on this initiative from medical school staff and students. Whilst generally positive, they were sceptical that GP societies (i) could extend influence beyond the already converted (ii) tend to have low attendance (iii) will fail to reach medical students scattered geographically on hospital placements (iv) lack research evidence of impact. It is most important that the RCGP fully evaluates this initiative to consider these reservations. GP presence at student career fairs is crucial.

Recommendation 10:

RCGP should evaluate fully the role of GP Societies, to optimise these societies and share good practice. General Practitioners need to be present at student career fairs. RCGP should work more closely with SAPC to link into medical schools.

Lead Responsibility: RCGP

Supported by: SAPC

Good Practice

RCGP – Student-led GP Societies

In recent times GP Societies have evolved considerably and now exist in 30 medical schools. The RCGP has in excess of 1,000 students across the UK engaging with their GP Society supported locally by the Regional RCGP Faculties. The success of this expansion lies in its strong student-leadership. RCGP is working to mobilise these student groups and to support the creation of vibrant and engaging student-led networks, campaigns, events and activities, including the introduction of a national student committee and a series of regional student-led conferences.

<http://www.rcgp.org.uk/training-exams/becoming-a-gp/student-hub/gp-societies.aspx>



Section 6

Hidden curriculum



“

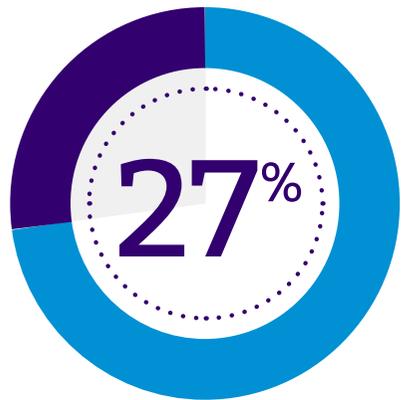
Our actions and policies, the institutions we create, should be eloquent with care, respect and love”

Nelson Mandela 1995

Section 6: the influence of the hidden curriculum

6:1 "Oh – don't be a GP - it is rubbish "*"

The strongest most consistent finding from all students, whether undergraduate or graduate, traditional or newer school and from the doctors in training on the working group, was that they experience very powerful anti-GP rhetoric, mainly within the hospital trusts at a challenging distance from medical school influence. An unpleasant cultural lack of care and respect for primary care exists deep within the hidden curriculum. As with psychiatry¹⁴ General Practitioners are repeatedly "bashed" and are the second least popular specialty.



of students had changed their career choice as a direct result of bashing

BASH: badmouthing, attitudes and stigmatisation in healthcare as experienced by medical students¹⁴

960 students from 13 medical schools completed a questionnaire ranking medical specialties according to the level of badmouthing and their experience of specialty bashing. The greatest number of negative comments from academic staff, doctors and students related to Psychiatry and general practice. 27% of students had changed their career choice as a direct result of bashing. Although 80.5% of students condemned badmouthing as unprofessional, 71.5% believed that it is a routine part of practising medicine.

6:2 "Hospital doctors blame General Practitioners a lot. You get the feeling that they are not liked. Not sure where the negativity comes from but it changes your opinions."*

Students repeatedly witness within hospital placements, negative comments mainly from consultants about GP referrals, missed diagnoses and patient management. This undoubtedly has a negative influence emphasising to students it is a "lesser" career. Some students, especially those who had had early exposure to general practice, have begun to appreciate the complexity of General Practitioners' work and that indeed many problems were solved without referral. They felt up to challenging these secondary care views but they did not know how to go about it and feared retaliation. We heard junior doctors were less disparaging. The misunderstandings between service delivery across the secondary-primary care "fault line" are undoubtedly damaging. It is time the profession addressed them.

6:3 "If a surgeon asks, I tell them that I haven't chosen a specialty yet so they don't treat me differently."*

The denigration is undoubtedly powerful. Students stated that, particularly with surgeons, if they were planning to be a General Practitioner, they would not reveal this when asked. They feared disparaging remarks and being subsequently ignored during the teaching. If their knowledge base appeared poor, even by failing to answer a question, students were seemingly punished and advised to head for general practice. Traditionally trained secondary care doctors need to understand the complexity of current primary care delivery where a broad multifarious knowledge base is essential. The irony is as health care has moved forward so rapidly general practice needs some of the brightest and best students. The profession itself has failed to recognise this change and is preventing the necessary recruitment.

“ One student failed an exam and during a discussion with a tutor mentioned they wanted to be a GP. The tutor's response was 'You'll be OK then' .”

Medical Student



6:4 "You have to be careful who you tell about wanting to be a GP. Juniors are nicer about it than the consultants."*

We learnt from medical school leads there is increasing awareness that students need support to become more self-assertive not only sharpened by the Francis report¹⁵, to raise concerns for poor professional practice but also to challenge disparaging unacceptable remarks from their seniors. This remains very difficult for them. They fear retaliation if, for example, they met the offending doctor in a clinical examination. One can argue this embedded professional culture has not deterred general practice recruitment in the past and is indeed very entrenched across different specialties. However as we aim for a values based NHS culture, all doctors whether in primary care or secondary care, must now take personal responsibility to create caring mutual respect in the clinical environment not only for the sake of those in training but also for optimum patient care.

Good Practice

Tackling the hidden curriculum

"Good thing I'm aware of the hidden curriculum otherwise his speech might have influenced my career aspirations!"

Messages communicated to students through the hidden curriculum, particularly from role modelling by clinicians, can have a powerful impact, positive or negative, on students' perceptions of different careers. Yet this learning, which is often unconscious, is rarely discussed with students or teachers. Since 2007, Peninsula Medical School has 'revealed' the hidden curriculum to students by including it as a formal topic. Students share hidden curriculum experiences in facilitated small group sessions, including examples of career stereotyping. Through discussion, they realise they can choose whether to take such messages on board or not: Training on the hidden curriculum is also offered to Faculty. By considering messages that they purposefully, or inadvertently, given to students, participants appreciate the importance of positive language and the need to "avoid making 'dismissive' comments", however subtle, about other specialties.

For further information on this work please contact
Professor Hilary Neve:
hilary.neve@plymouth.ac.uk

Recommendation 11:

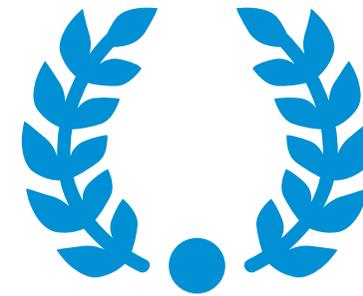
Work should take place to tackle undermining of general practice as a career across all medical school settings including primary care. This should include (1) incorporating "undermining" into Faculty development (2) teaching students about the hidden curriculum (3) developing student self-assertiveness to question denigration (4) improved feedback mechanisms to enable students to report safely on any serious undermining whilst on placement (5) work with the Academy of Medical Royal Colleges (AoMRC) to create a positive culture of professional respect.

Lead Responsibility: Medical Schools

Supported by: All Medical Royal Colleges AoMRC GMC
HEE MSC RCGP

Section 7

RCGP and SAPC



“

Openness and participation are encouraged where education and research are properly valued.”

Liam Donaldson

Section 7: external influences: the RCGP and SAPC

7:1 "There are no research opportunities in GP"*

Students perceive general practice does not offer an academic career pathway. If you aspire to do research, a hospital specialty is the default position. The Society for Academic Primary Care (SAPC) has highlighted the disparity between the low number of Primary compared to Secondary Care Academic University posts and the dwindling, rather than expanding, visibility of Departments of Academic Primary Care. This reinforces to students its low profile. Unresolved difficulties exist post NHS reorganisation and the loss of Primary Care Trusts over contracts and funding pathways to recognise academic General Practitioner achievements through Clinical Excellence Awards. The access to and funding of local awards in particular has not been clearly established.

7:2 The National Institute of Health Research (NIHR) offers positive opportunities for academic training. Academic Foundation Posts (AFPs), Clinical Fellowships (ACFs) and Clinical Lectureships (ACLs) in primary care exist nationally. These are valued by students. The availability of posts is extremely low in comparison to secondary care specialties. Of 250 ACFs awarded nationally each year across all specialties only 10-15 are placed in primary care. Expansion of these academic pathways and encouragement of students to work towards them is essential.

The UK's 205 senior academic General Practitioners comprise just 6.5% of all clinical academics, and a tiny fraction of the 64 923 General Practitioners currently registered with the General Medical Council ¹⁵

Good Practice

NIHR Integrated Academic Training

The Walport Report (2005) recommended development of explicit specialist training pathways to include dedicated academic training. NIHR Academic Clinical Fellowships (ACFs) allow GPSTs to undertake 25% research (including medical education) and 75% clinical training over four years. This scheme has had a positive impact not only on capacity building in academic general practice within medical schools but also in role modelling the academic opportunities within a GP career to students. Yet the number of GP ACFs per year, and hence medical schools involved, is alarmingly small; 10-15 (<6%) NIHR GP ACFs per year of a total 250 across all specialties. Small wonder medical students fail to appreciate the academic opportunities of general practice.

Recommendation 12:

Academic training opportunities in primary care should become more accessible by (i) increasing the availability and reviewing the current structure and support for Academic Foundation Posts (AFPs), Academic Clinical Fellowship (ACF) GP posts and Academic Clinical Lectureships (ACLs) (ii) active promotion of these opportunities within medical schools (iii) recommendation to NHS England to meet its contractual obligation to provide contracts to Senior Academic General Practitioners (SAGPs) and ensure access to and funding of local and national Clinical Excellence Awards.

Lead responsibility: NHS England

Supported by: HEE NIHR SAPC UKFPO

Outcome measure: Contractual obligations achieved and increase in GP ACFs and AFPs

7:3 "The RCGP is invisible at times, but some are aware via societies and the conference"*

We detected tensions within the General Practitioner membership over dedicating time to academic work and not doing the "real job"; a hardened traditional view that it is work at the coal face that matters. Students pick up on this. It deters those seeking flexibility of roles (see section 8). Apart from the loss of academically gifted students to secondary care in a competitive job market, unless reviewed, this arguably bodes ill for patients. There is a very significant need for greater visibility of primary care research in one of the most rapidly changing sectors of health care.

The balance of primary versus secondary care academics must be equitable. Resolving this tension is essential. The RCGP needs to fully understand that academic status for General Practitioners should be equivalent to that students witness in other specialties. Our evidence suggests it could inspire and enthuse academically gifted students to become General Practitioners and not default to secondary care. There is a strong opportunity for RCGP leadership to encourage and support the diversity of general practice.



7:4 Within primary care, the SAPC influence is more directly related to the MSC for both UG education and research. Two separate sections for Teaching and Research host medical school leads within each. They work within their Universities and nationally to gain appropriate resources for both UG education and research. In contrast the RCGP is less directly linked. Its internal educational organisational management structures focus on PG training. SAPC and RCGP hold separate annual conferences where some students welcome the opportunities to present projects from GP placements and build their CVs. We learnt that ironically some of them then use these to enhance competitive points for specialty training. For selection into GP training we were told that academic achievement is not positively recognised. This reflects the “work at the coal face” expectation of PG general practice training and reinforces the lower status of general practice in students’ eyes.



“

We're students that throughout the course have attempted in some small way to go a little bit above and beyond. All three of us have published research, done audits and have performed well academically. We've seen on placement what a fantastic career general practice is, how it can positively impact on many many patients and that it is very difficult to do well. It is no 'soft choice'.

Despite this the opening line of the recruitment speech was "...all those prizes, publications and extra achievements that you heard you needed for surgical and medical training, well, none of that is relevant to general practice.

In fact, there's not even space to put them on the application form, as if this was in some way attractive! It left the impression that if you had any of these extra achievements there was no place for you in GP - something we know to be nonsense. We believe GP needs to inspire to recruit students. Indeed, potential recruits will apply precisely because of its difficulty, not in spite of it."

A quote published with permission from an email sent to the Editor of the BJGP

7:5 As the RCGP membership increasingly includes General Practitioners early in training (approaching 50% of membership), resolution of these conflicts between the generations of doctors is key to recruitment. The College has acknowledged the need to engage with students and is developing a student strategy working group. This is a good move to understand the different perceptions of future careers in general practice and realign

with the younger membership. However many of the problems we have identified relate to finance and ensuring stronger links with SAPC, the MSC and Universities. Improving recruitment will need positive solutions for education roles across the UG and PG transition and measures to protect already limited resources. Very close collaboration between the RCGP and SAPC is we believe crucial to address the issues this report raises.

Recommendation 13:

All institutions influencing students should collaborate to raise the profile of academic general practice by ensuring (1) all students have access to, and are overtly valued and rewarded, for scholarly activity and visibly supervised by primary care leads (2) the profile of senior academic GP leaders is raised and appropriately acknowledged in all medical schools (3) Collaboration between the RCGP and SAPC is strengthened.

Lead responsibility: Medical Schools

Supported by: RCGP SAPC RCGP Clinical Innovation and Research Centre (CIRC)

Outcome measure: Report from RCGP/SAPC on agreed strategy

Good Practice

RCGP – Student Engagement Strategy

The RCGP plans to better inform, educate, support and empower the next generation of General Practitioners. The College cemented its commitment to this by developing a Student Engagement Strategy. Through the strategy, RCGP aims to build stronger relationships with students by: (i) Enhancing access and exposure to general practice, (ii) Providing engaging and informative careers guidance (iii) Supporting and empowering student-led activity and (iv) Nurturing positive student dispositions towards general practice.

Section 8

Graduation



“

Cultivate the society of the young, remain interested and never stop learning.”

Cicero

Section 8: student expectations on graduation

8:1 "There is variety: It can be flexible. You can go into education, research or CCGs which is appealing on paper but you don't see it in reality"*

We learnt that Generations Y and Z medical students have career aspirations which embrace diversity, flexibility, globalism and work life balance in many ways but hold, as they leave medical school, impressions and perceptions that risk non alignment with those of the current general practice workforce. They are attracted by the concept of a "portfolio" career with the potential to move between primary and secondary care and share clinical with academic responsibilities. For some established General Practitioners this resonates uncomfortably and challenges their values of continuity of care in a relatively restricted environment with full commitment to clinical practice. It would be foolish not to listen to and understand the students' views. They represent the future workforce.

Recommendation 14:

Increasing the awareness of and supporting portfolio careers within general practice alongside the core role of a General Practitioner is crucial. Strong collaboration across all organisations is needed to ensure the range of opportunities within general practice is actively promoted within medical schools and students are offered a far better understanding of what being a General Practitioner can offer.

Lead Responsibility: Medical Schools

Supported by: by HEE RCGP SABC

8:2 "It's a tough job. Anyone can walk through the door."*

Students frequently expressed understanding and respect for the work of a General Practitioner enforced by positive role models established, in some schools, very early in the curriculum. Consequently students could be irritated with, rather than negatively influenced by, the professional denigration they witnessed in the workplace. On the other hand words such as "scary", "tough job", "uncertain" and "stressful" emerged in conversation. Some students felt unconfident they would have the skills for the job. We learnt from trainees it takes time to have the "courage to go solo".

One can only guess at the numbers of medical students frightened or shamed out of a generalist career by the fear of omniscience as a requisite.¹⁶

8:3 "You need way more knowledge to become a GP. It's scary."*

Students raised concerns about the lack of flexibility of training, of great importance but beyond the scope of this report. The expectation that young doctors feel confident to enter general practice training immediately after Foundation experience, merged from discussions as flawed. This may also impact on failure at the selection process if they have not yet developed the necessary skills. We heard that the challenges of general practice, reinforced by General Practitioners themselves, leave doctors feeling they lack the necessary skills. The loss of the opportunity to enter broad based training was much mourned. Many General Practitioners have worked in secondary care before entering general practice. They have not fallen "off the specialist career ladder" but have made a definite choice as and when they felt it was appropriate. Students gave us a valuable insight into how the "scary" leap from hospital to primary care and a relatively "lonely" environment can deter them.

8:4 "A patient once said 'never believe anything a GP says, they've only trained for 3 years'">*

The current length of general practice training was frequently discussed. We heard two directly opposing views. For some, particularly graduate students, the three year programme is attractive as a relatively short route to completing a certificate of training. For others it did not make sense that such a difficult career which required such breadth of

knowledge and skills should have such a relatively short training programme. This reinforced their perception both that it is held as a less skilled specialty compared to secondary care and fears that they would not be confident enough to then practice independently. Trainees on four year extended training schemes endorsed the need for a longer training programme.

8:5 "I saw it as a means to work to live rather than live to work"*

Work life balance was also debated. Whereas some had originally perceived general practice offered "work to live rather than live to work", they had come to realise on placements that days in practice were long and arduous. It was not an "easy" life. For female students the option of part time work and flexibility to bring up families remained attractive. There was general awareness from the General Practitioner role models they met in medical schools, who were successfully combining education or research with clinical practice, that general practice could offer the combination of work balance across clinical, specialty interest and the "intellectual" challenge they aimed for.

8:6 Students throughout their time in medical school are weighing the evidence to make a personal informed decision. It is not a choice made by chance or easily swayed. Their overall message is they want an intellectually challenging career. For Generation Y and Z students this needs to embrace flexibility and mobility. In the current competitive market, the strong image of general practice of "lower status" must be rectified. Medical schools must work to erase this perception, challenge professional denigration within the profession itself and make it clear within the curriculum what being a General Practitioner involves. However ultimately only General Practitioners and their professional representative organisations can raise its image as a challenging intellectual specialty and address the negative messages students risk receiving when placed in primary care itself.

Recommendation 15:

Promotion of GP careers should be carefully considered to ensure that students have the ability and flexibility to make informed career decisions without feeling pressured by market forces: (1) Information provided should be honest, accurate and accessible (2) Existing General Practitioners should champion the vision of the profession as an exciting intellectually challenging and rewarding career.

Lead Responsibility: Health Careers

Supported by: HEE RCGP SAPC Medical Schools All General Practitioners

Abbreviations:

ACF	Academic Clinical Fellowship	MMI	Multi Mini Interview
ACL	Academic Clinical Lectureship	MSC	Medical Schools Council
AFP	Academic Foundation Post	MSCSA	Medical Schools Council Selection Alliance
AoMRC	Academy of Medical Royal Colleges	NAHT	National Association of Head Teachers
BJGP	British Journal of General Practice	NIHR	National Institute of Health Research
BMA	British Medical Association	PC	Primary Care
BMAT	BioMedical Admissions Test	PCC	Patient Carer Community
CCG	Clinical Commissioning Group	PG	Postgraduate
CEPN	Community Education Provider Networks	RCGP	Royal College of General Practitioners
CIRC	Clinical Innovation and Research Centre	SAGP	Senior Academic General Practitioner
DH	Department of Health	SAPC	Society for Academic Primary Care
GMC	General Medical Council	SSP	Special Study Programme
GP	General Practitioner	SIFT	Service Increment For Teaching
GPC	General Practitioner Committee	UG	Undergraduate
GPST	GP Specialty Trainee	UGMT	Undergraduate Medical Tariff
HEE	Health Education England	UKFPO	United Kingdom Foundation Programme Office
HEI	Higher Education Institution	UKMED	UK Medical Education Database

GLOSSARY:

Formal Curriculum

The formal curriculum of an institution of higher learning is the outlined objectives, content, learning experiences, resources and assessment required in order to earn a specific academic degree.

The **“informal curriculum”** refers to lessons that are not explicitly taught. In medicine, there are skills doctors learn that are rarely recorded in textbooks or overtly discussed during rounds or lectures

The **“hidden curriculum”** consists of the unspoken or implicit academic, social, and cultural messages that are communicated to students

The **“multi mini interview” (MMI)** consists of a series (up to 10+) stations each marked by one assessor where candidates are presented with various pre-designed tasks. These carefully planned to ensure a wide range of skills and attitudinal behaviours is assessed.

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Appendix 1: Literature review

An online literature research was carried out at the start of the project by two HEE clinical fellows; Dr James Somauroo with Dr Maslah Amin Maslah. HEE Library services conducted the literature search. The findings informed the structure of the three subsequent workshops.

Questions asked of the review were:

- (i) prior to starting medical school, what are the factors that predispose medical students to choosing general practice, around the world?
- (ii) At medical schools around the world, what are the factors that positively and negatively affect medical students' decision to become a GP?
- (iii) What innovations can medical schools in the UK adopt to increase the number of medical students choosing general practice?

Sources searched were Embase, HMIC, Medline (PubMed and HDAS) databases. Key words used were career choice; education; medical; undergraduate; medical students; premedical; general practice; family practice; General Practitioners; medical graduate. In addition relevant websites were accessed and searched for information: BMA, BMJ Careers, Council of Deans of Health (CoDH), Google, GP Magazine/GP online, Higher Education Academy, King's Fund, Pulse, RCGP. In addition bibliography of the relevant manuscripts was hand searched to identify all potentially eligible manuscripts. The search was restricted to 2010-2015.

Two hundred and ninety four papers were identified from 46 countries; more than 60% came from the USA, UK and Germany. All papers were read and analysed. Peer reviewed research papers with appropriate methodology and sample size were selected for further analysis under three headings "Selection" (34 papers), "Curriculum" (66 papers) and "Promotion of general practice" (39 papers). Themes drawn from these papers were presented at the three workshops to provide an evidence base for discussions.

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Appendix 2: recommendations by organisational responsibility

DEPARTMENT OF HEALTH

Recommendation 1:

Current funding systems, processes and guidance for distributing monies for undergraduate teaching must be reviewed urgently to enhance and ensure equity for the quality and quantity of learning for medical students across the health care system.

Lead Responsibility: DH

Supported by: BMA GPC HEE MSC NHS England RCGP SACP

Outcome measure: Current discussions to progress to ensure an appropriate tariff can be introduced by April 2018

GENERAL MEDICAL COUNCIL

Recommendation 5:

All medical schools must revise their undergraduate curricula to ensure they develop to reflect the patient journey through different health care settings and offer a more integrated less specialty organised approach. The GMC must review its Outcomes for Graduates to provide guidance appropriate to rapidly changing workforce needs. This is essential to ensure students are prepared for more flexible careers and future health and care delivery.

Lead Responsibility: GMC

Supported by: Medical Schools

Outcome measure: Revised GMC recommendations in one year

Recommendation 7:

General practice should be recognised as a specialty in its own right with a combined register.

Lead Responsibility: GMC

Supported by: BMA RCGP

Outcome measure: Single register with General Practitioners as Consultants in Primary Care

MEDICAL SCHOOLS COUNCIL

Recommendation 2:

Develop, promote and disseminate positive, realistic awareness and understanding of general practice to pupils in primary and secondary education. Areas of focus must include:

1. Medical schools outreach and widening participation activities
2. Fora to provide interaction between school/college pupils and staff

Lead Responsibility: MSC

Supported by: BMA CCGs GPC HEE Other GP primary care organisations RCGP SACP

Outcome measure: MSC led Audit of resources

Recommendation 3:

Improve access to and quality of work experience in general practice for prospective medical students. Work to achieve this should be collaborative and include:

1. Sharing and co-promotion of existing materials, toolkits and models
2. Practices to be encouraged to provide structured work experience opportunities

Lead Responsibility: MSC

Supported by: All primary care commissioners including NHS England and CCGs BMA GPC HEE RCGP SACP Medical Schools

MEDICAL SCHOOLS

Recommendation 4:

All medical schools must ensure that General Practitioners contribute significantly in all selection processes. Schools must build on the work of MSCSA on selection methods including values based recruitment and the UK Medical Education Database (UKMED) to understand characteristics influencing career trajectory and the differential general practice workforce outputs.

Lead Responsibility: Medical Schools

Recommendation 6:

The formal curriculum must better inform medical students on NHS management and delivery at the primary – secondary care interface. Students should recognise the breadth and complexity of general practice care and be stimulated by the complex intellectual challenge. The business elements of, and career options within, general practice (e.g. partnership versus salaried or locum roles) need to be clear to students.

Lead Responsibility: Medical Schools

Supported by: GMC RCGP SAPC

Recommendation 8:

An increase in UG general practice placements must address improved quality, content, timing and variety. This should include exposure to (1) a variety of practices (large, small, rural, urban) (2) general practice Multi-Disciplinary Teams (3) the range of general practice services. Equitable and appropriate financial resourcing is essential to achieve this.

Lead Responsibility: Medical Schools

Supported by: GMC HEE RCGP SAPC

Recommendation 9:

Positive and enthusiastic General Practitioner role models should be identified and made visible across all medical schools. This includes enhancing and supporting the role of General Practitioner Specialist trainees (GPSTs) as educators and assessors and interaction in primary care between medical students and near peers in training.

Lead Responsibility: Medical Schools

Outcome measure: Directors of PG GP Education MSC PG Deans, RCGP Specialty Advisory Committee

Recommendation 11:

Work should take place to tackle undermining of general practice as a career across all medical school settings including primary care. This should include (1) incorporating “undermining” into Faculty development (2) teaching students about the hidden curriculum (3) developing student self-assertiveness to question denigration (4) improved feedback mechanisms to enable students to report safely on any serious undermining whilst on placement (5) work with the Academy of Medical Royal Colleges (AoMRC) to create a positive culture of professional respect.

Lead Responsibility: Medical Schools

Supported by: All Medical Royal Colleges AoMRC GMC HEE MSC RCGP

Recommendation 13:

All institutions influencing students should collaborate to raise the profile of academic general practice by ensuring (1) all students have access to, and are overtly valued and rewarded, for scholarly activity and visibly supervised by primary care leads (2) the profile of senior academic GP leaders is raised and appropriately acknowledged in all medical schools (3) Collaboration between the RCGP and SAPC is strengthened.

Lead responsibility: Medical Schools

Supported by: RCGP SAPC RCGP Clinical Innovation and Research Centre (CIRC)

Outcome measure: Report from RCGP/SAPC on agreed strategy

Recommendation 14:

Increasing the awareness of and supporting portfolio careers within general practice alongside the core role of a General Practitioner is crucial. Strong collaboration across all organisations is needed to ensure the range of opportunities within general practice is actively promoted within medical schools and students are offered a far better understanding of what being a General Practitioner can offer.

Lead Responsibility: Medical Schools

Supported by: by HEE RCGP SAPC

HEALTH CAREERS

Recommendation 15:

Promotion of GP careers should be carefully considered to ensure that students have the ability and flexibility to make informed career decisions without feeling pressured by market forces: (1) Information provided should be honest, accurate and accessible (2) Existing General Practitioners should champion the vision of the profession as an exciting intellectually challenging and rewarding career.

Lead Responsibility: Health Careers

Supported by: HEE RCGP SAPC Medical Schools All General Practitioners

NHS ENGLAND

Recommendation 12:

Academic training opportunities in primary care should become more accessible by (i) increasing the availability and reviewing the current structure and support for Academic Foundation Posts (AFPs), Academic Clinical Fellowship (ACF) GP posts and Academic Clinical Lectureships (ACLs) (ii) active promotion of these opportunities within medical schools (iii) recommendation to NHS England to meet its contractual obligation to provide contracts to Senior Academic General Practitioners (SAGPs) and ensure access to and funding of local and national Clinical Excellence Awards.

Lead responsibility: NHS England

Supported by: HEE NIHR SAPC UKFPO

Outcome measure: Contractual obligations achieved and increase in GP ACFs and AFPs

RCGP

Recommendation 10:

RCGP should evaluate fully the role of GP Societies, to optimise these societies and share good practice. General Practitioners need to be present at student career fairs. RCGP should work more closely with SAPC to link into medical schools.

Lead Responsibility: RCGP

Supported by: SAPC

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Health Education England	Dr	Robert Carter	GP Dean Directors – Representative
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Notes



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